



West Virginia

EPI-LOG

Fourth Quarter/2014
Volume 33, No. 4

Workplace wellness programs promote healthy behavior and cut costs for employers

A workplace wellness program is a health promotion activity or organization-wide policy designed to support healthy behavior and improve health outcomes while at work. These programs consist of activities such as health education and coaching, weight management programs, medical screenings, on-site fitness programs, and more.

Wellness programs include policies intended to facilitate employee health, including allowing time for exercise, offering healthful food options in vending machines, holding “walk and talk” meetings, and offering other incentives for participation.

Effective workplace programs, policies, and environments that are health-focused and worker-centered have the potential to significantly benefit employers, employees, their families, and communities. Changing our behavior is ultimately up to each of us as individuals. However, employers have a tremendous opportunity to help their employees see the value of adopting healthier behaviors so they can live healthier lives. A workplace culture sets the tone for its employees. A supportive work environment, where managers reinforce a sound wellness strategy, can keep employees motivated and engaged. Wellness and incentive programs can be used to drive and reinforce healthy behaviors, bringing benefits to the employer, the employee, and the community.



(See **Wellness**, page 2)

Statewide Disease Facts & Comparisons

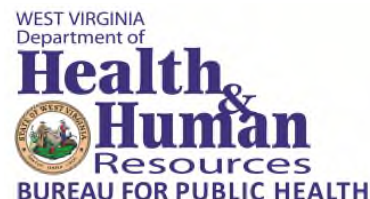
A quarterly publication of the West Virginia Office of Epidemiology & Prevention Services

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Earl Ray Tomblin, Governor
Karen L. Bowling, Cabinet Secretary
Dr. Rahul Gupta, Commissioner and State Health Officer

(Wellness, continued from page 1)

There are four focal points in a typical workplace wellness program:

- Nutrition
- Exercise
- Stress reduction
- Tobacco cessation

Health improvements are achievable by providing targeted health promotion and disease prevention programs that reduce modifiable risk factors, often the cause of costly chronic diseases. Instituting environmental and policy interventions, in addition to individual behavior change programs, may shift our thinking about how we pay for health. When employers provide wellness programs to their employees, they demonstrate how risk reduction and disease prevention in the workforce make good sense economically.

It is often said that an ounce of prevention is worth a pound of cure. While naysayers may argue that screening costs for healthy people far outweigh treatment costs for the few who develop the disease, disease prevention and health promotion can provide high value to society.¹

Promoting Health and Wellness in the Workplace

It is really hard to change people's health habits, especially those set in their ways. Conversely, changes in physical activity and eating habits in the past few decades have sharply increased the prevalence of obesity. Causes for this dramatic rise in obesity include more driving by Americans and less walking and bicycling; new labor-saving appliances in the home; increased consumption of ready-made foods and larger portion sizes; more time spent watching TV, using computers, and video gaming; and more sedentary occupations. These changes in social norms and



practices have altered our health and health habits in both positive and negative ways.² Workplaces represent a microcosm of society since they contain concentrated groups of people who share a common purpose and culture. If you think about it, employers have a built-in incentive for keeping people healthy. If employers' health promotion efforts are successful, workers use health care services sparingly, they have lower absenteeism, their disability rates decrease, worker safety improves, and productivity is improved. When done right, this presents a "win-win" for employees and employers. Changing behavior is possible—it has been done before, and we can do it again.

Senior executives and line managers in an organization need to be aware of the wellness program and consistently support it from the top down. Without the clear support of senior leadership, a wellness program may fail.

Leadership

The leader's duties may include some or most of the following:

- Developing a vision of the wellness program after receiving input from employees.
- Communicating ideas and a rationale throughout the organization (to management and employees).
- Building energy, enthusiasm and commitment towards the program.
- Serving as a role model and wellness coach.
- Developing and maintaining leadership skills, such as giving effective presentations and being well-organized.

Evaluating Success

A wellness program should include mechanisms or steps to regularly monitor progress and evaluate the success of the program. For example, one can track the number of participants in a given activity, or the number of employees who indicate support for some or all components of the program.

Regular evaluation allows for:

- Identifying areas of excellence.
- Identifying factors that affect program participation.
- Maintaining management support for everyone's efforts.

(See Wellness, page 10)

Biosense 2.0: The future of health surveillance for West Virginia

BioSense 2.0 is West Virginia's new electronic syndromic surveillance system. BioSense 2.0 is governed through a collaboration of Centers for Disease Control and Prevention (CDC), state and local health departments, and other public health partners and operates on a distributed cloud computing environment. As part of the State's effort to enhance health-related situational awareness, West Virginia is implementing BioSense 2.0. In September 2012, the Office of Epidemiology and Prevention Services (OEPS) received a 3-year CDC grant to implement BioSense 2.0 in West Virginia. The OEPS works with the West Virginia Health Information Network (WVHIN), which is the designated electronic health data aggregator for the State, in recruiting and onboarding State hospitals with Emergency Departments (EDs) that have electronic medical records to provide syndromic data. West Virginia has 48 hospitals with EDs.

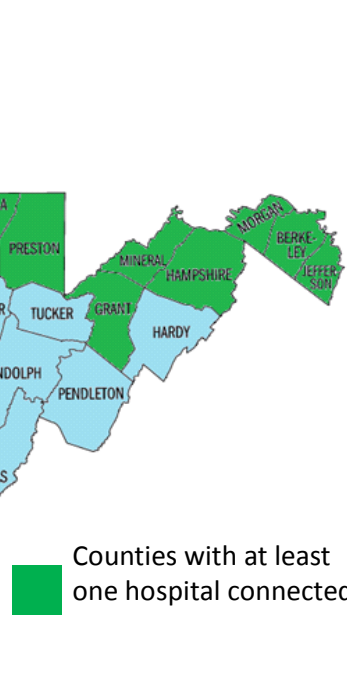
Proposed/Ongoing Activities

The objective of the CDC grant is to connect at least 24 West Virginia hospitals' EDs to BioSense 2.0 before the end of the 3-year grant. Hospitals willing to provide ED data to WVHIN's Health Information Exchange (HIE) are connected to the HIE and to the state-secure space (or "locker") in the BioSense 2.0 cloud. The WVHIN establishes

connections between participating hospitals to the HIE's cloud-based system. Hospitals that do not provide data to the HIE, but otherwise are eligible and willing to participate, will be directly connected to the state locker with CDC's technical assistance. The OEPS has already established connection with the BioSense 2.0 cloud and is able to monitor ED visits.

Current Status

As of January 2015, 30 facilities, including four urgent care centers are submitting near real-time data to BioSense 2.0. The users of the system can access near real time de-identified, aggregate data on various health threats of interest. This will enable West Virginia's public health system to monitor local, state, and national health related threats.



BioSense 2.0 will strengthen West Virginia's syndromic surveillance by allowing easy, yet secure access to the data by different users; systematic review and comparison of disease trends across geographic jurisdictions in a timely manner; estimation of disease burden in hospital EDs; and sharing of selected surveillance data within and across local jurisdictions, other states and the CDC. The timeliness and easy availability of data is important in guiding West Virginia's targeted review of selected health conditions, as well as plan and budget resources accordingly. Syndromic data from BioSense 2.0 is expected to be valuable for surveillance of infectious diseases, chronic diseases, injuries and behavioral health issues. BioSense 2.0 also enables the West Virginia Department of Health and Human Resources to support meaningful use programs on syndromic surveillance. ☒

**West Virginia AIDS and HIV Infection Cases Diagnosed by
Age Group, Gender, Race and Exposure Category
Cumulative through December 31, 2014**

Characteristic	HIV/AIDS ‡		HIV-NA ‡		AIDS ‡	
	No.	%	No.	%	No.	%
Age at Diagnosis §						
< 13 years	23	1	10	1	13	1
13 - 24 years	355	13	232	24	123	7
25 - 44 years	1,822	64	587	61	1,235	66
45 - 64 years	587	21	130	13	457	25
65 + years	43	2	8	1	35	2
Gender						
Males	2,290	81	729	75	1,561	84
Females	542	19	239	25	303	16
Race/Ethnicity						
White	2,081	73	639	66	1,442	77
Black	632	22	279	29	353	19
Other*	119	4	50	5	69	4
Exposure Category						
Male-to-male sex (MSM)	1,509	53	483	50	1,026	55
Injection drug use (IDU)	410	14	144	15	266	14
MSM/IDU	127	4	30	3	97	5
Heterosexual contact	402	14	161	17	241	13
Perinatal	23	1	10	1	13	1
Other/Unknown†	361	13	140	14	221	12
Total	2,832	100	968	100	1,864	100

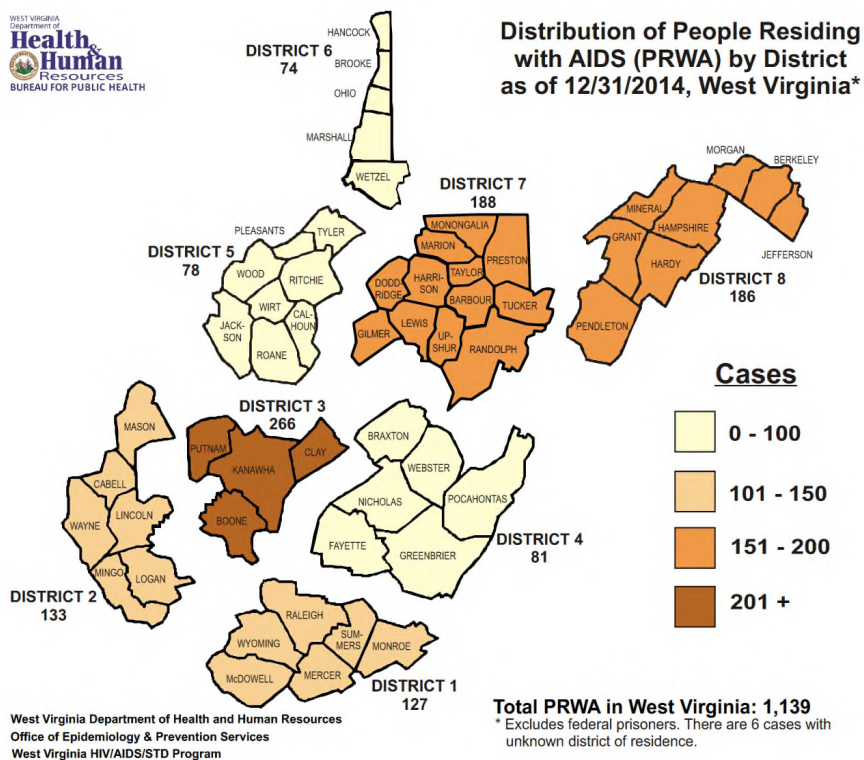
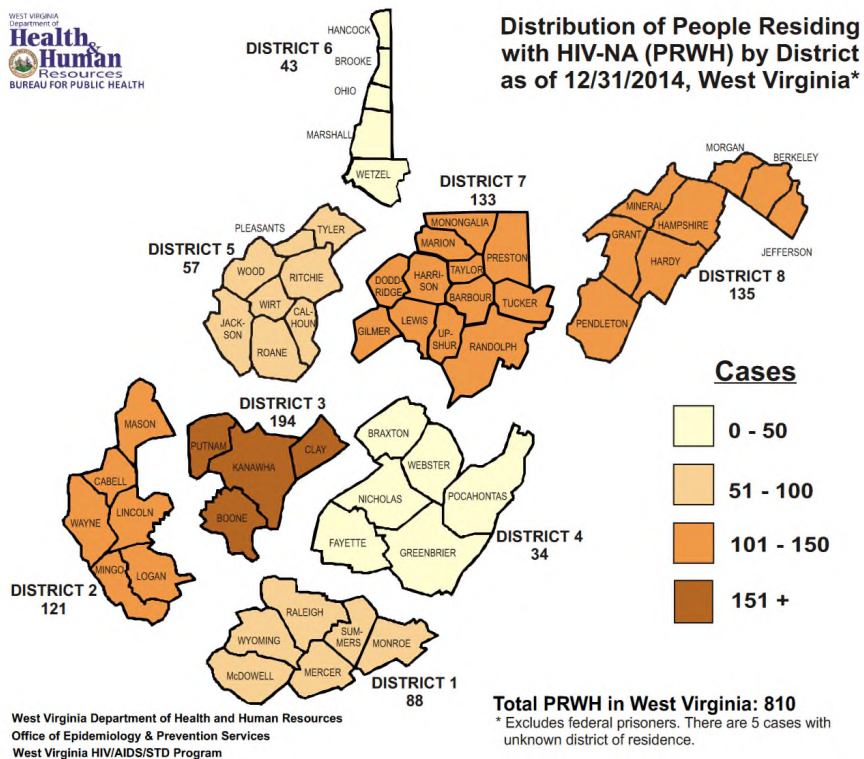
Notes: These are actual numbers of cases of HIV/AIDS that were reported to the WV Department of Health and Human Resources as of December 31, 2014. No adjustments were made for reporting delays. AIDS data includes reports from April 1984 through December 31, 2014; HIV data includes reports from January 1989 through December 31, 2014. Federal prisoners have been excluded. Percentages may not add to 100% due to rounding.

‡ HIV/AIDS provides information on the person's earliest diagnosis of HIV or AIDS in WV. HIV-NA provides information on individuals diagnosed with HIV but not AIDS in WV. These individuals may have been diagnosed with AIDS in another state. Individuals with AIDS may or may not have been diagnosed with HIV in WV.

*Other race categories include Hispanic, Asian, Native Hawaiian, Pacific Islander, American Indian, Alaskan Native, Multiple Races, and Unknown race.

†Other/Unknown risk categories include hemophilia, blood transfusion, and risk not reported or not identified.

§ Total includes two persons with unknown age at diagnosis.



West Virginia Infectious Disease Outbreak Report

October - December 2014

Introduction

In West Virginia, outbreaks are immediately reportable to local health departments (LHDs) regardless of setting, as per Reportable Disease Rule 64CSR-7. LHDs, in collaboration with the West Virginia Bureau for Public Health, Division of Infectious Disease Epidemiology (DIDE), investigate all reported outbreaks. DIDE provides outbreak surveillance reports on a monthly and annual basis, and upon request. This report provides a brief description of confirmed outbreaks during the last quarter of 2014. All data provided is provisional, since several investigations are ongoing.

Methods

Data on outbreaks are routinely compiled in Microsoft Excel 2010. Data analyzed for the purpose of this report includes information on outbreak type and setting, reporting region, time of reporting to LHDs and DIDE by region, clinical diagnosis, and laboratory information.

Results

During the months of October, November, and December 2014, there were 59 outbreaks reported in West Virginia. Of the 59 reported outbreaks, 53 (90%) were confirmed as outbreaks or clusters of disease. Six were investigated and determined not to be outbreaks. Thirty-four were reported from healthcare facilities, nine from schools, six from daycares, one from a residential center, one from a sports team, one from a community, and one from multiple schools in one county.

Among the 34 healthcare-associated outbreaks reported, 29 were from long-term care facilities (LTCFs), four from assisted living facilities, and one from a rehabilitation center.

The following tables summarize the confirmed outbreaks from October through December 2014.

Respiratory Illness Outbreaks (n=28)

Type of Outbreak or Cluster	Number of Outbreaks	Outbreak Setting	Laboratory Testing
Influenza	22	16 LTCFs	7 PCR* Confirmed 9 RIDT** Confirmed
		3 Assisted Living	1 PCR* Confirmed 2 RIDT** Confirmed
		1 Rehabilitation Center	RIDT** Confirmed
		1 Multiple Schools	PCR* Confirmed
		1 School	RIDT** Confirmed
Acute Respiratory Illness	5	4 LTCFs	1 Not Done 3 Negative or Non-contributory
		1 School	Not Done
Rhinovirus Respiratory Illness	1	1	PCR* Confirmed

* PCR: Polymerase Chain Reaction ** RIDT: Rapid Influenza Diagnostic Test

(See **Outbreaks**, page 7)

(Outbreaks, continued from page 6)

Enteric Disease Outbreaks (n=8)

Type of Outbreak or Cluster	Number of Outbreaks	Outbreak Setting	Laboratory Testing
Acute Gastroenteritis	6	4 LTCFs 1 Daycare 1 Assisted Living	Not Done Negative or Non-contributory Not Done
Norovirus Gastroenteritis	1	LTCF	Lab Confirmed
Giardiasis	1	Community	Lab Confirmed

Rash Outbreaks (n=14)

Type of Outbreak or Cluster	Number of Outbreaks	Outbreak Setting	Laboratory Testing
Fifth Disease	2	Schools	Not Done
Hand, Foot and Mouth Disease (HFMD)	10	4 School 5 Daycare 1 Sports Team	Not Done Not Done Not Done
Scabies	2	LTCFs	Not Done

Multidrug-Resistant Organism (MDRO) Outbreaks (n=2)

Type of Outbreak or Cluster	Number of Outbreaks	Outbreak Setting	Laboratory Testing
<i>Clostridium difficile</i>	1	LTCF	Lab Confirmed
Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)	1	Residential Center	Lab Confirmed

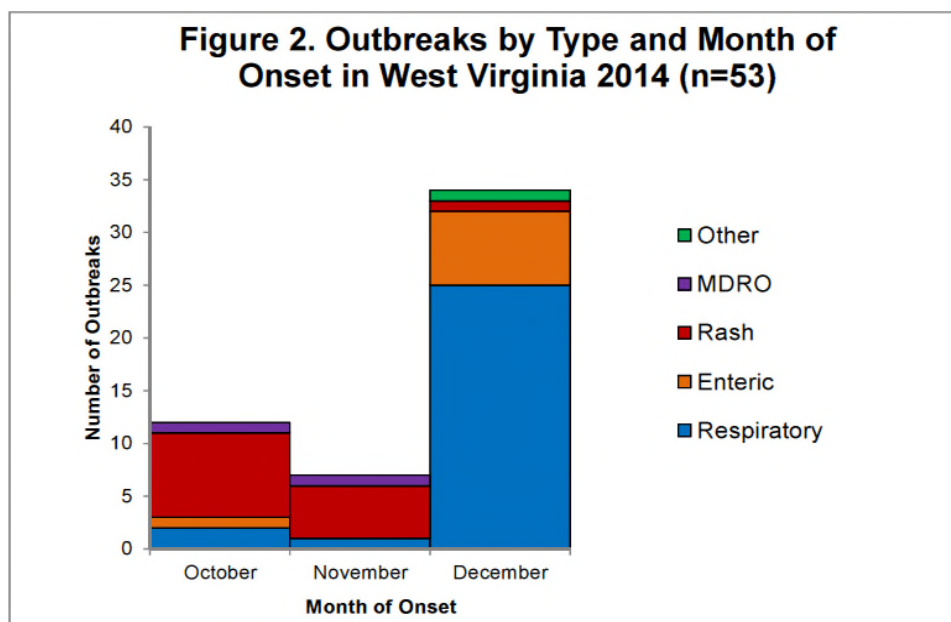
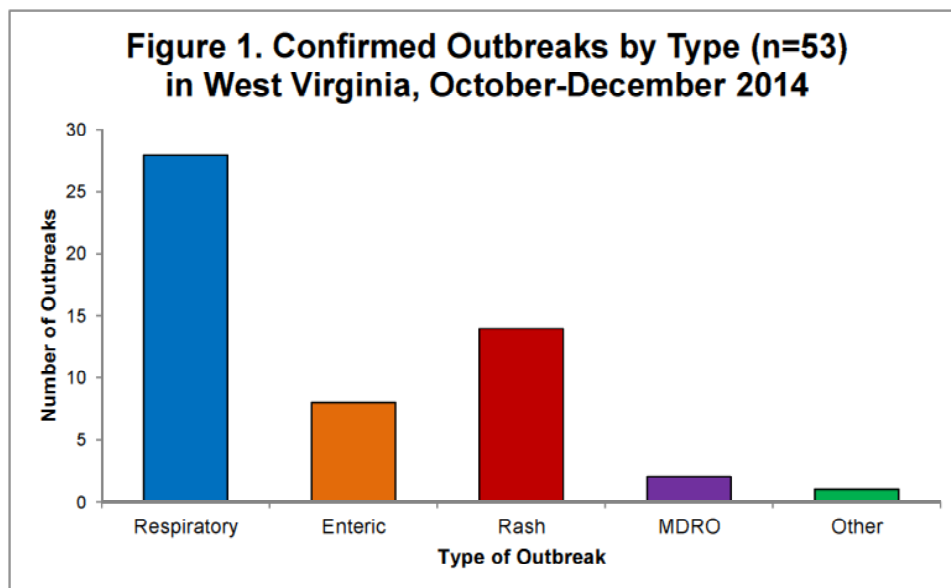
Other Outbreaks from (n=1)

Type of Outbreak or Cluster	Number of Outbreaks	Outbreak Setting	Laboratory Testing
Acute Febrile Illness	1	School	Not Done

(See **Outbreaks**, page 8)

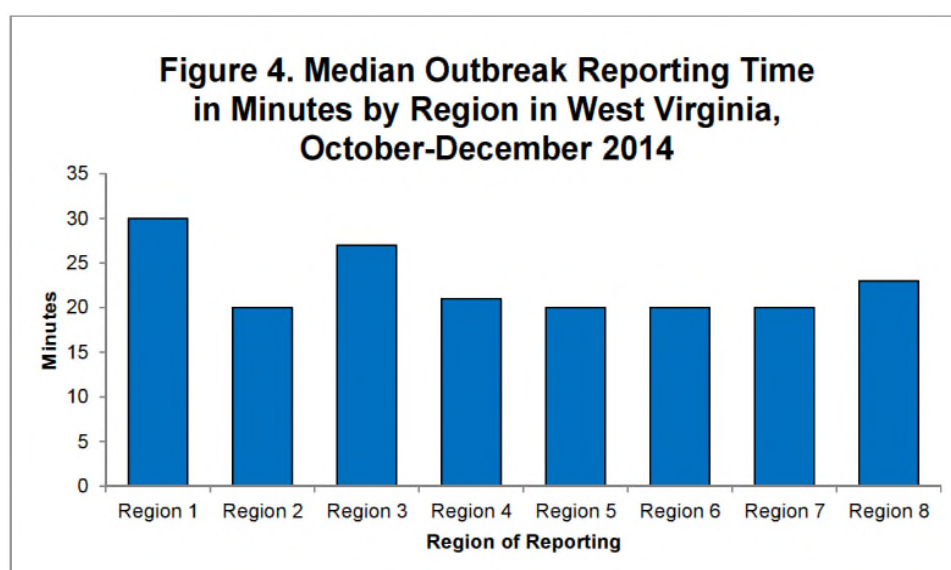
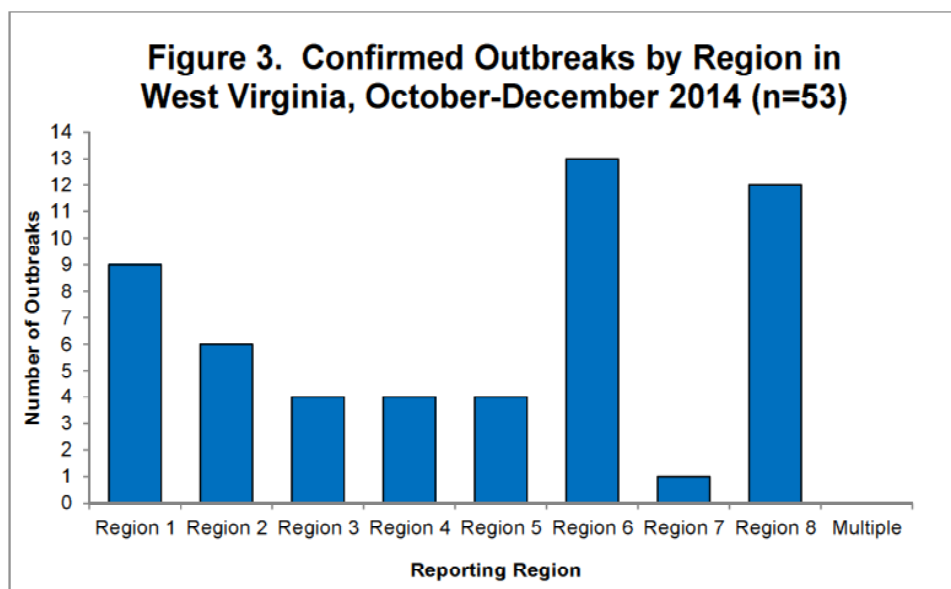
(Outbreaks, continued from page 7)

Respiratory outbreaks were the most common outbreaks reported during this period (Figure 1, below). Respiratory outbreaks have increased from two outbreaks in October to 25 outbreaks in December (Figure 2, below). The majority of respiratory outbreaks 22 (79%) were due to influenza. All surveillance regions reported outbreaks during this period (Figure 3, page 9). The mean and median reporting time in minutes between local and state health department was 75 (24). Of the 53 confirmed outbreaks, 46 (87%) were reported within one hour to DIDE. Figure 4 (page 9) illustrates the median reporting time in minutes by region.



*(See **Outbreaks**, page 9)*

(*Outbreaks*, continued from page 8)



Limitation

Data provided in this report is provisional since some investigations are ongoing.

Conclusions

There was marked increase in influenza outbreaks during the month of December, which suggests an early start of a severe influenza season. This influenza season, so far, is disproportionately affecting elderly populations. As a result, the majority of influenza outbreaks were reported from healthcare facilities, specifically LTCFs. LHDs should be prepared to investigate and manage more than one influenza outbreak at a time in their jurisdictions. DIDE commends the LHDs for the marked improvement in timely reporting of outbreaks.

For information on outbreak guidelines or any disease or condition, please visit the Division of Infectious Disease Epidemiology's website at www.dide.wv.gov, call (304) 558-5358, ext. 1, or toll free in West Virginia: (800) 423-1271. ☒

(*Wellness, continued from page 2*)

- Understanding of issues that need attention.
- Learning from mistakes and changing the program to keep it on the right track.


When evaluating a wellness program, one can also track core measurables, such as:

- Employee absences.
- Employee turnover rates.
- The cost of the employee assistance program.
- The cost of benefits, including short-term and long-term disability payments.
- Incident rates and safety records.
- Employees' participation in wellness programs and whether they're staying in them.
- Changes in employees' health habits.

- Level of employees' awareness of healthy lifestyle issues.
- Results of workplace wellness audits.
- Other noticeable changes in areas such as employee morale and job satisfaction.

The Behavioral Risk Factor Surveillance System is a state-based system of health surveys that collects information on health risk behaviors and health conditions. Currently, the survey is conducted by the West Virginia Health Statistics Center in collaboration with the CDC.

References

1. L. Breslow, "From Disease Prevention to Health Promotion," *Journal of the American Medical Association* 281, no. 11 (1999): 1030–1033.
2. 2012 West Virginia Behavioral Risk Factor Survey Report WV Health Statistics Center, 2012. <http://www.wvdhhr.org/bph/hsc/pubs/brfss/2012/BRFSS2012.pdf> 

*The **West Virginia EPI-LOG** is published quarterly by the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Epidemiology & Prevention Services. Graphic layout by Chuck Anziulewicz. Please call the Office of Epidemiology & Prevention Services at (304) 558-5358 if you need additional information regarding any article or information in this issue. If you have ideas or contributions you would like to make in a future issue, ask for editor Loretta Haddy.*